Twenty-four were married and had produced 43 children.

Only half preferred men for company, and social reasons were said to be responsible for the homosexual behaviour in about 40%. The homosexual impulse was first experienced at an average of 16.6 years. In some cases homosexuality replaced heterosexuality, but rarely after the early twenties.

In 65.6% initiation was by persons of the same age. Seduction by an older male occurred in 14, but in only 4 by a relative. Military service was not responsible, but group boy and youth activities were suspect. School life was not implicated.

Of the cases, 90% indulged with boys alone or boys and adults.

Dream life of the cases reflected their basic homosexuality.

Other homosexuals in the family were reported by only five—two brothers, two maternal uncles, and a cousin.

The direction of the libido was not influenced by hormones or psychotherapy, but its force was reduced by treatment with oestrogens. Few patients desired treatment, and most of these only to reduce the urge so as to avoid reconviction.

Assessment of these cases and the problem of homosexuality were greatly clarified by using the Kinsey homosexual–heterosexual rating scale.

We wish to express appreciation to the Prison Commissioners for affording us every facility to carry out this work and to publish it (although it does not necessarily represent their views); to the hospital officers of H.M. Prisons, Leyhill and Bristol, for their whole-hearted co-operation; and to the many prisoners who willingly submitted to examination and study in the hope that society might benefit.

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The United Hospitals Choir is open to new members. Rehearsals are held every Thursday from 7.30 p.m. to 10 p.m. at St. James's and St. Peter's School, Great Windmill Street, London, W.1, and canteen facilities are available before and during rehearsals. Further details may be obtained from the secretary, Miss J. Magrath, 18, West Side, Clapham Common, London, S.W.4 (BATtersea 0310), from 7 p.m. onwards.

THE CURE OF HOMOSEXUALITY

BY

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In the Wolfenden report the statement is made (p. 66), "We were struck by the fact that none of our medical witnesses were able, when we saw them, to provide any reference in medical literature to a complete change of this kind"—namely, a change in the direction of the sexual propensity from his own sex to that of the opposite sex.

The implication of this statement should not remain unchallenged; for it encourages the view that homosexuality is incurable. There must be many medical psychologists who could point to cures of this radical kind.

It is indeed commonly held that homosexuality is constitutional; that is to say, inherent in the physiological make-up of the individual; that as one person is naturally and constitutionally heterosexual, so, it is said, another is naturally homosexual. This carries with it the verdict: "Once a homosexual, always a homosexual."

Whether there are such constitutional cases cannot be dogmatically stated. There appears to be no direct evidence of this. Havelock Ellis maintained that homosexuality was of a constitutional type, but he admitted to me in person that he made this statement only because he wanted to emphasize that the individual could not help being what he was. But that would be equally so if the condition was due to psychological experiences in early childhood, for which the person is equally not responsible.

Indeed, the case of homosexuality differs little from other perversions such as fetishism in which the sexual impulse is transferred to an inanimate object like corsets or the hood of a perambulator, which can hardly be a constitutional propensity; and which can be cured by discovery of their infantile origin. If the sex instinct can be transferred to such objects as corsets, or patent-leather shoes, there seems no *a priori* reason why it should not be transferred or perverted to those of the same sex.

It is, however, not the purpose of this article to deal with such theoretical considerations, but to deal with the clinical aspects of treatment and cure.

What is Cure?

By "cure" I do not mean the normal transition from the homosexual to the heterosexual phase in adolescence (the "sight of a pretty girl" can do this); nor do I mean that the homosexual is merely able to *control* his propensity, whether on moral grounds or from fear of punishment, important as that is from the sociological point of view. Nor even do I mean, as it is claimed, that by religious conversion a person may lose his homosexual *desires*, unless he becomes heterosexual. Indeed, it is obviously not necessarily a sign of cure that the patient is rendered capable of having sex relations and bearing children; for, as the report states, he might do this by the help of homosexual fantasies. By "cure" I mean that he loses his propensity to his own sex and has his sexual interests directed towards those of the opposite sex, so that he becomes in all respects a sexually normal person.

If there is, in fact, a lack of cures of homosexuality, it is probably because in investigating the psychological causes we do not go far enough back.

For the orientation of homosexuality, and the deviation from the normal, appears from the following cases to go back to a much earlier age than is usually supposed; and only when these factors are revealed and dealt with is the patient radically cured.

It is fallacious, for instance, as the report says, to assume that homosexuality *originates* in a sexual assault by another male at puberty. It is true that such an assault may be the *precipitating* cause, and without this the youth might not have developed into a homosexual. But that in itself is insufficient as a complete explanation of the condition. For, if that were the case, far more boys would develop into homosexuals, since such assaults are a common experience in schooldays, and not merely in boarding-schools. Why is it that one boy so assaulted in puberty becomes a homosexual and another does not? It is because of earlier *predisposing* factors; and these appear to be of a psychological rather than a constitutional type.

The following cases demonstrate these facts and the possibility of radical cure.

Old Cases

Before coming to recent cases, mention may be made of four cases of homosexuality treated over 30 years ago, with three of whom I have recently made contact, the fourth having died in the meantime. These are given to indicate the completeness and permanence of the cure. Two of these were completely homosexual, and both had an attraction to the backside of boys, though neither was a practising homosexual. The other two were not entirely homosexual; for they were married and had children, but were able to have intercourse only by virtue of homosexual fantasies. Each preferred, and practised, homosexuality—the one in the form of mutual masturbation, the other of sodomy.

All four patients were completely cured of their perverse propensities, and all have remained cured, with no further episodes, by discovering the causes of their disorder in early childhood.

As an illustration of such causes let us take the patient who has since died.

His homosexual practices dated from the age of 11, when he was seduced by an "old boy" visiting his preparatory school. But that was only the precipitating cause. His history as revealed in analysis was briefly as follows. He had a mother who was very sensuously disposed towards him and aroused his sexual feelings by her cosseting and fondling. She died when he was 3, and he was put in charge of a strict and rigid aunt who gave him no affection. He grew up a sad and lonely boy throughout his early and school life. Reviving the experience of the assault at school, he declared that it was not the sex pleasure which intrigued him so much as the fact that someone had given him the notice and affection of which he had been starved since early childhood. The sexual practice now became the symbol of all the love and affection which he so much craved, and of course increased as adolescence advanced. It persisted into adult life, and ultimately got him into trouble with the police, which forced him to seek treatment. In analysis his original repressed sexual feelings towards his mother (obviously heterosexual) were revived, and, being released, developed as they would have developed if they had never been repressed. As a result of treatment he declared that he had completely lost the desire for youths, which after all was only a substitute for the loss of mother love, and he became completely heterosexual. The last I heard of him (prior to his death) was a paragraph in a daily paper saying that his wife was suing him for divorce for running off with another woman—which, if not the most desirable outcome of the analysis, at least confirmed the transference of his feelings from homosexuality to heterosexuality.

In the two cases of complete homosexuality where there was an attraction to boys' buttocks it was found that these objects of love were substitutes for the breast, which is a very common form of substitute, considering their similar shape, smoothness, softness, and body smell. Being ruthlessly deprived of the breast, the child resorted to auto-erotism as a solace, but with breast fantasies. Later the affection was transferred to an object reminiscent of both these desires—namely, to the buttocks, which were reminiscent of the breast, and to another male, someone like himself. The narcissism (self-love) which was adopted as a substitute for the mother's love was turned into homosexuality. Homosexuality is self-love once removed.

By the release of these early complexes, which fixated and so perverted their sexual propensities, these two complete homosexuals, like the partial ones, lost their perverse tendencies, and have been happily married for over 30 years (to the one woman in each case). They have children, and there have been no relapses. The basic causes of all four cases lay in infantile life.

Recent Cases

Mention may first be made of a particularly fortunate and exceptional case of a practising homosexual of 26. He had an undemonstrative mother who gave him no affection. But he received affection from the age of 3 or 4 from his older brother in bed at night, expressed in mutual masturbation, a habit which persisted with other males through school into adult life. Whether there were deeper causes was not revealed, for he lost his homosexual tendencies in five treatments, got married, had children, and three years later (writing to get advice concerning his brother, who also required psychological treatment), said that "marriage is a great success."

Such a cure in so short a time is, of course, quite exceptional, and a bit of pure luck, but nevertheless the cure appears to be radical and, so far, permanent.

A more typical case was that of a naval officer aged 25 who was a practising homosexual with no heterosexual interests; indeed, he avoided women, and this took him to join the Navy. In analysis he traced his symptoms back to infancy, when he was being breast-fed by his mother, got sexual feelings, gulped down his food, and choked. In reviving this incident he repeatedly choked and choked till he was blue in the face. This choking was repeated for some 15 to 20 interviews, till he "got it out of his system." This infantile experience produced fear of his mother and so fear of women generally, especially in their sensuous or sexual aspect, for it was in the process of enjoying himself sensuously that the disaster occurred.

It might be said that other children have these infantile experiences without becoming homosexual. That is true, and admittedly the factors mentioned are not the only ones; much depends on later experiences. If, for instance, this child had received love and reassurance from his mother, he would probably have overcome his fear of her and of women in general, and so have developed normally. Unfortunately his mother was a self-centred and selfish woman who did not bother with him. So his fear remained and his only resort was to his auto-erotism, which persisted throughout early childhood. This was later associated with fantasies of an "imaginary companion" with whom he indulged in mutual masturbation, and transferred itself later to actual male companions. The revelation of these causes abolished his fear of women. He has married, has children, and writes to say that "marriage is wonderful."

Another case is that of a non-practising homosexual, a barrister. He had a very difficult birth (which he relived in treatment with great horror), in which he felt his chin was caught on his mother's pelvic girdle, incidentally resulting in a tic of his head, now cured. He thus started off life with the sense of insecurity, which was not helped by the fact that his mother was busy divorcing his father at that time and handed him over to an unscrupulous nurse. This nurse used to tease him and put him into furious rages with her, and then stimulated him sexually to check his rages. His mother would come in at his screaming, and ask what was the matter, to which the nurse would "innocently"

reply, "I don't know!" and of course the child could not explain. This made him furious with his mother also for not understanding. Henceforth he regarded all women as a wash-out. He found solace in masturbation (the nurse having initiated him into sex feelings), which he could now indulge in without the taunts of the nurse. He later transferred these sex feelings towards boys, with homosexual fantasies of a sadistic nature, since the stimulation of his genitals by the nurse was associated with rage. His attitude towards women was that of anger and resentment, not mainly of fear, as in the previous case. It was a very prolonged treatment, but he is quite cured and is very happily married.

Another patient, a medical man, had the misfortune to be born with defective genitals. He had several operations in childhood, and suffered severe pain from the catheter his mother had constantly to pass. His mother assumed a grim attitude about the whole business; his father ignored his defect and never referred to it; and his brother was unsympathetic and went his own way. At public school he was laughed at, and was scorned and bullied on account of his defect. In this lonely, loveless life the one thing in the world he craved was sympathy and companionship, and especially with someone who would not scorn his defective genitals. The desire for homosexual affairs was mainly a desire for sympathetic companionship. But more specifically his attraction to the male genitals of another was his desire to *possess* a normal penis of his own *like that*. The release of all his early miseries and humiliation in a sympathetic atmosphere cured him of his homosexual desires. He sublimated his need for friendship and companionship in social and religious work, and, though a full marriage is out of the question, he has normal desires towards the opposite sex. The homosexual desires bother him no more.

A patient, a business man in the City, at present under treatment, has a tying-up sex perversion with boys; but a repugnance to the other sex. In imagery he reverts to being at the breast in infancy, being embraced and held tight in his mother's arms and getting an erection; whereupon his scandalized mother put him in his pram and strapped him in. He is furious, struggles, and in his struggle presses against the strap. This produces the same sex feelings as when he was pressed in his mother's arms. He therefore substitutes the strap for his mother's lost embrace, and later transferred this to being tied up. The recovery of this experience and the feelings associated with it cured his perversion. But he cannot be regarded as yet cured, for, though his symptom is no longer there, his sex feelings have not yet been transferred to heterosexuality, and treatment continues.

Discussion

Such cases as these, few and inconclusive as they are, appear to demonstrate that homosexuality *can* be cured in the full sense, provided we can trace the condition to its basic causes. These patients were cured when, and only when, their propensities were traced back to infantile experiences.

These cases inevitably raise many questions: for instance, how are these early memories revived · are they memories of real experiences or are they fantasies; how does the discovery of the causes lead to cure?

This is not the place to discuss these problems (which have been dealt with in my *Psychology and Mental Health*, and in many other books on psychopathology), the purpose of this article being purely clinical and not theoretical.

One thing may be stated, however, that these revivals of the origins of the perversions came from the patients themselves and were not the result of any preconceived theory or any suggestions on the analyst's part. Each case was taken at its face value, and, as in all medical work, an attempt was made to discover the specific cause, however deep-rooted, in each case.

It is the fashion now to decry these early memories. It is said that it is inconceivable that a patient can relive such early experiences. Whether these early "memories" were true or imaginary, the fact remains that these patients were cured, and radically cured, when, and only when, these experiences were revived. If these experiences were just fantasies, how are we to explain the fact that imaginary fantasies should have such a salutary effect in curing an otherwise incurable condition? The argument from inconceivability is the weakest of all arguments.

In any case, there is no reason why experiences such as I have mentioned should not be true. Instances like that of suffocation at the mother's breast and consequent fear of females is not such an impossible experience for a child to have; nor is it inconceivable that this should produce a fear of women; nor that this should make him turn into himself and then to others of his own sex for gratification.

Nor is there any reason why experiences of infancy should not be recovered. An infant of a few days or weeks old has retention and reproduction of previous experiences, and gets excited when it sees its mother preparing to feed it. There is no reason why, if we can remember what happened to us at the age of 4, we cannot be made to remember what happened to us at 6 months. If it is dogmatically maintained that it is impossible for an adult to revive the experiences of infantile life, the onus of proof of this lies with those who make such assertions. What proof is there that these experiences cannot be revived?

On the other hand, when one sees the patient choking and struggling for breath, it leaves one with little doubt that such reproductions are real—as real as when a shell-shock patient relives under hypnosis the experience of being blown up or buried; and with the same result—namely, the release of the repressed emotions, the relief of the patient, and the abolition of the symptoms.

While these cases demonstrate the possibility of cure, in some cases at least, of homosexuality, the fact remains that it is usually very difficult to cure, not only because its roots are so deep, but also because of the patient's reluctance to get rid of a symptom which, afer all, is his main pleasure in life. The treatment is very time-consuming. In the choking case it required 164 treatments: some cases need even more. Whilst one is healing one homosexual, one might be treating two or three patients suffering from other forms of neurosis. It is for that reason, together with the uncertainty of getting the patient's full co-operation, that I no longer take homosexuals on for treatment, for the number of cases any one analyst can treat is limited.

There have, of course, been failures in the intervening period. One was a famous actor—a complete homosexual with transvestist fantasies and practices. I failed to get him freely associating, and after 12 interviews said that it was hardly worth continuing. In a letter he wrote a week or so after, he said he had only come in order to prove that homosexuality was incurable—no doubt to salve his conscience.

In a further instance of failure, that of a regular "young man about town," the homosexuality was associated with anxiety. Since the anxiety was the more distressing symptom to the patient, this was taken first, as a gateway to the treatment of the homosexuality. The anxiety was cured, with the result that the patient said, "Thank you very much," and was able to carry on with his homosexuality without anxiety—a comforting situation for him, but hardly a desirable issue of the treatment.

Three others had to be given up; for though they wanted to be cured, as evidenced by their coming for treatment, either because of the subconscious reluctance to lose their symptom or because of lack of persistence, they gave it up.

Finally, there was the case of a clergyman who was anxious to be cured, and, so far as I could see, was sincere

in his desire and co-operative, but, in spite of great persistence on both sides, he was not cured. As there did not seem to be any constitutional abnormality, it can only be assumed that this failure was due to some defect in technique.

Analytic treatment is in itself no solution to the whole problem of homosexuality, because of the time-consuming factor. But the continued investigation of such cases is desirable, for, if the causes of homosexuality as lying in infantile experiences can be substantiated it should be possible by avoiding these experiences to prevent it. If the causes in each of the cases mentioned are studied, it is evident that they could have been prevented by different treatment at the hands of the parent. The prevention of homosexuality, like that of all the other neuroses, seems to lie in right parenthood.

Summary

The origin of homosexuality and other deviations from the normal seems to originate in very early childhood experiences. Cases are given, some relating to treatment 30 years back, and others more recent, which indicate that when these causes are discovered and the experiences revived the patient is able to adjust himself to them in a way he was unable to do as an infant, and is thereby cured. This process of cure is a long one, and cannot be considered a practical answer to the widespread incidence of homosexuality. Probably the main benefit in analysing these cases and the discovery of their causes is that we may find the means to prevent them.

APPLICATION OF ANTIBIOTICS (POLYBACTRIN) IN SURGICAL PRACTICE, USING THE AEROSOL TECHNIQUE

BY

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The occurrence of infection in elective surgical operations is a major clinical problem, varying in severity from place to place and from time to time. Most cases of this infection are due to a type of *Staphylococcus aureus* relatively resistant to penicillin, and, in recent years, increasingly resistant to the broad-spectrum antibiotics. Of the remainder, many are the result of infection by *Pseudomonas pyocyanea,* which is also resistant to most of the antibiotics in common use.

Increase in Resistant Strains

Barber and Rozwadowska-Dowzenko (1948) drew attention to the rising incidence of penicillin-resistant strains of *Staph. aureus* and reported that in a London hospital the incidence had risen from 14% in 1946 to 59% in 1948. Many similar reports have been published, and in the U.S.A. it is thought that 75–80% of staphylococcal infections in hospitals are caused by penicillin-resistant strains (Long, 1955; Spink, 1955). The high incidence is so far confined to in-patients, but there is some evidence that penicillin-resistant infections are also appearing with greater frequency among out-patients (Rees *et al.*, 1955). Persistent, hardy, and adaptable potentially pathogenic staphylococci are ubiquitous in the hospital environment and continue to produce strains resistant to the antibiotics most often used in clinical practice.

Many factors and circumstances are responsible for surgical sepsis. Busy operating theatres in use throughout the 24 hours, defective or outdated theatre and dressing-room ventilation systems, nasal carriers of resistant bacterial strains commonly found amongst hospital staff, unreliable methods of skin decontamination, the use of local vasoconstrictor solutions (adrenaline) for infiltration of the wound area, breaches of surgical technique; all these, in different places and in different circumstances of varying importance, may combine or permutate to increase the risk and incidence of surgical infection. In the last analysis, however, surgical infection is caused by the implantation of pathogenic organisms by aerial contamination, droplet spread, or direct surgical implantation into the exposed wound at the time of operation. While, obviously, the attack on sepsis in any particular surgical organization may be on one or all of the fronts mentioned above, the problem may not be soluble by attention to them.

One method of tackling the problem is by the use of topical antibiotics, to destroy or combat the pathogens as they are or may be, implanted in the wound at operation.

While "asepsis" in the strict etymological sense is an unattainable ideal, the practical aim must be the minimal bacterial contamination of a "clean" surgical wound.

It is probable that local conditions adverse to combating infections (dead tissue, adrenaline ischaemia, operating-time, foreign-body implants) are reasonably constant factors when considered in relation to a series of 250 neurosurgical operations such as are reported below. The dosage of contaminating pathogens is the variable and decisive factor. Unless this contamination can be controlled in some way, the case for a topical antibiotic is rendered mandatory. If the desirability of such a topical preparation is granted, it is important that the chosen preparation should neither sensitize patients nor favour the emergence of resistant strains.

For such a topical preparation a number of known antibiotics, too toxic for systemic use but with a wide range of effectiveness of action and negligible tendency to increase resistance, may be considered. Polymyxin, bacitracin, and neomycin, which are poorly absorbed into the body from "raw" tissue surface, have recently been prepared as an antibiotic triad ("polybactrin") for local use. The application of this combination requires special consideration on account of its relative insolubility and instability in aqueous solutions.

These difficulties have been overcome by suspending an intimate mixture of the antibiotics in an inert, highly volatile anhydrous liquid, "dichloro-tetrafluoro-ethane." The preparation is contained under pressure in a receptacle which permits "pushbutton" discharge of the antibiotic mixture as an aerosol. By this means the antibiotics can be dispersed evenly on any desired wound site. The high concentration and high bactericidal activity of the triad limits the risk of resistant strains emerging.

This antibiotic triad has recently been used in a clinical trial for the prophylaxis of surgical sepsis at the Department of Surgical Neurology in the Royal Infirmary of Edinburgh. The price paid for sepsis in Neurological Surgery, in terms of mortality, morbidity, and bed utilization, may be great, and any practical steps to limit or minimize its incidence are valuable.

Method

The antibiotic is released from its container by pressure on the releasing valve at its top. From a distance of 8–10 in. (20-25 cm.) the projected antibiotic triad is directed into the wound, care being taken to ensure even distribution. In this trial the wound was sprayed at each wound layer encountered on opening and closing. For example, during craniotomy the under surface of the scalp and the exposed pericranium were sprayed after reflection of the scalp flap; the bone flap, with its attached muscle, and the dura were sprayed when the bone flap had been elevated. On closure the order was reversed: firstly the dura, then the bone flap and muscle, next the pericranium and under surface of the scalp, and finally the wound edges, were treated after their approximation by deep galeal sutures.